		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JETIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED 04/13/2012	
			B. WIN	G		04/13/	2012
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					N MICHIGAN RD		
HEARTH	AT TUDOR GARD	ENS LLC		ZIONSV	/ILLE, IN 46077		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
R0000							
			Doo.	00			
	This visit was for the Investigation of			00			
	Complaints IN00	0106034 and					
	IN00104084.						
	Complaint IN001	106034 - Substantiated.					
	State deficiencies related to the allegation						
	are cited at R052	and R091.					
	Complaint IN00104084 - Substantiated.						
	•	elated to the allegations					
	are cited.						
	are cited.						
	Survey dates: A	pril 10, 11, 12 & 13,					
	2012	pm 10, 11, 12 & 13,					
	2012						
	Facility number:	012262					
	•						
	Provider number						
	AIM number: N	/A					
	a .						
	Survey team:						
	Christi Davidson	, RN-TC					
	Census bed type:						
	Residential: 105						
	Total: 105						
	Census payor typ	e:					
	Other: 105						
	Total: 105						
	Residential samp	ole: 5					
	r						
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	E	TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/01/2012 FORM APPROVED OMB NO. 0938-0391

I	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/13/2012
	PROVIDER OR SUPPLIE		11755	ADDRESS, CITY, STATE, ZIP CODE N MICHIGAN RD VILLE, IN 46077	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	These state find accordance with	_			
		1/17/12 by Suzanne			

State Form Event ID: TR0X11 Facility ID: 012263 If continuation sheet Page 2 of 18

	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	ONSTRUCTION 00	(X3) DATE : COMPL	ETED
			B. WIN			04/13/	2012
	PROVIDER OR SUPPLIER		•	11755	ADDRESS, CITY, STATE, ZIP CODE N MICHIGAN RD VILLE, IN 46077		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
R0052	(1) sexual abuse (2) physical abuse (3) mental abuse (4) corporal puni (5) neglect; and (6) involuntary se Based on observer record review, the a resident was from and neglect, related ensure an allegated immediately report and the memory care for abuse remains the memory care. Findings include The record of Reform 4/13/12 at 10: Diagnoses include to, degenerative in hip, dementia, hy anxiety, and inso	s - Offense ve the right to be free from: ; se; shment; seclusion. ation, interview and se facility failed to ensure see from physical abuse sted to the failure to sion of abuse was orted to the or 1 of 5 residents segation went she employee who sa resident causing her to oved from the facility sation, and the potential sed for the 32 residents in unit. (#H) : sident #H was reviewed 00 a.m. ded, but were not limited sjoint disease of the left repertension, depression,	R00	52	1. As soon as the incident wa reported to the Administrator of 4/12/12 our policies and procedures were followed. During the investigation on 4/12/12 into the incident on 3/1 it came to the Administrator's attention that a resident was allegedly pushed the ground by an LPN. During investigation period Employee and Employee #2 were suspended. The Administrator and Business Office Manager conducted interviews with 6 employees that were present the evening in question: March 2012. The investigation concluded with differing eye witness accounts and no physproof of abuse by any employer Both employees were reinstatto full time work status. 2. The Administrator interviewed other employees and residents that were in the community on the evening of March 7, 2012. No other incidents were reported suspicious. 3. On 4/20/12 the Administrator conducted an abuse in-service for all staff members. The in-service attendance sheet is submitted.	7/12 a to the #1 r for 7, ical ees. ted he er	04/20/2012

State Form Event ID: TR0X11 Facility ID: 012263 If continuation sheet Page 3 of 18

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/13/2012
	PROVIDER OR SUPPLIER		11755	ADDRESS, CITY, STATE, ZIP CODE N MICHIGAN RD VILLE, IN 46077	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	independently w was independent to ileting and person service plan indicassistance with b requirements for encouragement to bathe requires cabathes (sic) ofter gets aggressive wapproached for box memory are genemonitoring and genemonitoring	bathing repeated to bathe. Difficult to the manager to give a D/T [due to] resident with staff when the mathsJudgement and the rally good. Needs guidance" It Fall Risk Evaluation dicated Resident #H was the was disoriented x 1, the past 3 months, had the while standing/walking dications in the categories did increase the risk of		appendix A. This in-service included clear definitions of a abuse policy, appendix B. Special focus was put on the courage that it may take for friends and co-workers to repother friends and co-workers abuse is suspected. All employees took a post test, appendix C, including true/fa questions and a specific que regarding who they would re abuse to. The answers to the were reviewed during the in-service. It is clear to all employees that suspected all is to be immediately reported the Administrator. The Administrator's name and phenumber was placed in highly visible areas around the community for employees to report abuse appropriately. The Administrator will condusample interviews of 2 staff members monthly specifically asking for any unreported or questionable incidents. All directors will reassure employ of their open door for communication.	e port if lse stion port e test puse if to one 4.
	indicated, "Res [clothes on after s room to allow Red de-escalateRes naked. Staff atte	ted 3/7/12 at 7:15 p.m. resident] refused to put shower. Staff exited Res es time to came out into hallway empted to redirect Res began screaming and			
	hitting at staffS	Staff left Res alone to began following staff			

State Form Event ID: TR0X11 Facility ID: 012263 If continuation sheet Page 4 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	NSTRUCTION 00	COMP	E SURVEY PLETED 3/2012	
	PROVIDER OR SUPPLIER		11755	ADDRESS, CITY, STATE, ZIP COI N MICHIGAN RD /ILLE, IN 46077		
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	into other Res ro striking outFar [and] MD [medial A nurses note dated indicated, "Res control of the carring (sic) town her head" A nurses note dated indicated, "Res at and followed states res room door of around struck states."	oms swearing and nily [and] management cal doctor] notified." ted 3/7/12 at 7:40 p.m. out in hallway naked el [and] swinging it over ted 3/7/12 at 7:50 p.m. again came out of room ff memberRes pushed oen and as staff turned off in the faceRes ning and throwing self at		CROSS-REFERENCED TO THE APP		
	indicated, "Res o	ted 3/7/12 at 8:00 p.m. came to nursing station, r and hit door screaming				
	indicated, "Thi [emergency med Res to ER [emer [evaluation]Re	ted 3/7/12 at 8:10 p.m. s writer contacted EMS ical system] to transport gency room] for eval s would not allow this kin at this time."				
		ted 3/7/12 at 8:20 p.m. arrived to transport				
	The record lacke	d documentation of any				

State Form Event ID: TR0X11 Facility ID: 012263 If continuation sheet Page 5 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LDING	NSTRUCTION 00	(X3) DATE : COMPL 04/13 /	ETED	
	PROVIDER OR SUPPLIER		S. 1111	STREET A	ODDRESS, CITY, STATE, ZIP CODE N MICHIGAN RD VILLE, IN 46077		
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	a.m., LPN [Licer indicated a CNA Assistant] witnes down a resident. incident involved CNA who witnes was CNA #2. During an intervent p.m., CNA #5 in pulled her braid of combative. She assisting her in good shower when the CNA #5 indicated [name of CNA #42's ear, from whearring, started by the combative p.m., CNA #2 in shift in the memory p.m., CNA #2 in shift in the sh	iew on 4/12/12 at 11:45 ised Practical Nurse] #6 [Certified Nursing ised a staff member push She indicated the d Resident #H and the ised the alleged abuse iew on 4/12/12 at 12:28 dicated Resident #H had but when the resident was indicated CNA #2 was iving Resident #H a resident was "upset." d the resident "went for 2]" and indicated CNA interest the second of th					

State Form Event ID: TR0X11 Facility ID: 012263 If continuation sheet Page 6 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
			B. WIN	G		04/13/	/2012
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SUPPLIER				N MICHIGAN RD		
HEARTH	AT TUDOR GARD	ENS LLC		ZIONSV	/ILLE, IN 46077		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		and left the resident.					
		d the resident came out					
	of her room without clothes on and						
	chased the CNAs						
		d they attempted to					
		dent. CNA #2 indicated					
		Medication Aide] #4					
	came out to help. The resident could not						
	be re-directed and LPN #3 came to assist.						
	CNA #2 indicated the four CNAs paired						
	off 2 and 2 to continue giving resident						
	care to the other residents in the memory						
	care unit while QMA #4 and LPN #3						
	continued to care	e for Resident #H. CNA					
	#2 indicated whi	le her and another CNA					
	were giving care	to a different resident in					
	the resident's roo	m, Resident #H came in					
	and pulled out a	braid extension from that					
	CNA's hair and h	nit CNA #2 in the ear					
	causing it to blee	d. CNA #2 indicated					
	LPN #3 and QM	A #4 took Resident #H					
	back toward her	room.					
	CNA #2 indicate	d she witnessed LPN #3					
	walk behind the	resident and push the					
		room causing the					
		nd knock into TV trays in					
		#2 stated, "[Name of					
		and said, 'she fell, right?'					
	_	resident." CNA #2					
		[‡] 4 had left the resident to					
	,	2 indicated she was the					
		NA #2 indicated she					
	1 -	porway and saw the					
		CNA #2 indicated she					
	-35144111 get up.						

State Form Event ID: TR0X11 Facility ID: 012263 If continuation sheet Page 7 of 18

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	00	COMP	ESURVEY LETED
AND I LAN	o. condection	DENTI TOTATION NOMBER.	A. BUILDING			3/2012
			B. WING	ADDRESS, CITY, STATE, ZIP COD		· - -
NAME OF I	PROVIDER OR SUPPLIEF	8		N MICHIGAN RD	,L	
HEARTH	AT TUDOR GARD	ENS LLC		/ILLE, IN 46077		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG		ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DLI ICILITO I		DATE
	_	ner CNA to help her at to get dressed as the				
		d naked. CNA #2				
	indicated when she returned with another					
		#H was "calm and sweet."				
	-	ted Resident #H could				
		hat happened. CNA #2				
		bulance came and				
		dent #H out of the				
	•	2 indicated she did not				
	1	nt to the administrator,				
	_	e memory care unit, or				
		ursing because she was				
		B and was afraid of				
		inistration. CNA #2				
		s aware of facility policy.				
		e was supposed to report				
		e indicated she learned				
	about recognizin	g and reporting abuse in				
	her CNA classes					
	During an interv	iew on 4/12/12 at 3:30				
	p.m., the Admin	istrator indicated he was				
	not aware of the	abuse allegation				
	involving LPN #	3. The Administrator				
	indicated he was					
	Resident #H had	escalated behaviors and				
	1	LPN #3 by 911 call to				
		ic evaluation on 3/7/12.				
		or indicated staff				
	interviews had b					
	_	esident's behaviors and				
		d was not aware of the				
	allegation of LP	N #3 pushing and causing				

State Form Event ID: TR0X11 Facility ID: 012263 If continuation sheet Page 8 of 18

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	00		ESURVEY LETED
MDILAN	OI COMMETION	IDENTIFICATION NOWIDER.	A. BUILDING			3/2012
			B. WING STREET A	ADDRESS, CITY, STATE, ZIP COI		-
NAME OF F	PROVIDER OR SUPPLIEF	₹		N MICHIGAN RD	~ ~	
HEARTH	AT TUDOR GARD	DENS LLC		/ILLE, IN 46077		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	CTION	(X5)
PREFIX	1	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
		fall during the episode. For indicated he would				
	report the allegation to the state agency, immediately remove LPN #3 from duty					
	and begin an inv	•				
	Administrator indicated he was not aware					
	that at least one employee was afraid to					
	report an allegation of abuse.					
	report an unegation of abuse.					
	During an observ	vation on 4/13/12 at				
	11:15 a.m., Resi	dent #H's room was				
	observed to be in the middle of a hallway					
	away from the m	nain activity room and				
	dining room. Th	ne memory care unit is				
	designed in a squ	uare.				
	On 4/12/12 at 12).15 mm tha				
	On 4/13/12 at 12	covided an employee				
	sign-in sheet rela	2 2				
	_	rvice dated 3/16/12 at				
	2:30 p.m.	Tylee dated 3/10/12 at				
	p					
	On 4/10/12 at 10):45 a.m., the				
	Administrator pr	rovided the Abuse Policy				
	dated 9/27/11 an	d indicated this policy				
		rrent. The policy				
		ports of suspected or				
		or neglect must be				
	presented immed	-				
		Confirmed abuse/neglect				
	_	to the State Department				
	of Health within	24 hours of the				
	occurrence"					

State Form Event ID: TR0X11 Facility ID: 012263 If continuation sheet Page 9 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		04/13/2012
	ADOLUBED OF STATE			ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER			N MICHIGAN RD	
	AT TUDOR GARD	ENS LLC		VILLE, IN 46077	
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	During an interv	iew on 4/10/12 at 11:00			
	a.m., the Admini	strator indicated that all			
	allegations of abuse or neglect must be				
	reported to the state agency.				
	1	5 5			
	On 4/11/12 at 3:0	05 p.m., the			
	Administrator provided the most recent				
	•	n Addendum dated			
	4/11/12. The Ab				
		ated, "Prevention of			
	_	ill be provided upon			
	_	l thereafterEmployees'			
	•	ity is to proved (sic)			
	_	if there is a potential of			
	abuse or harm to	a residentEmployees			
	will report all sit	uations that may be			
	considered abuse	or neglect to a resident			
	from any and all	sources. Retaliation to			
	residents, employ	yees or others who report			
	suspected abuse	-			
	-	rts of suspected or			
		or neglect must be			
	presented immed	•			
	Administrator				
	Aummstrator				
	This state finding	g relates to complaint			
	`	z relates to complaint			
	IN00106034.				

State Form Event ID: TR0X11 Facility ID: 012263 If continuation sheet Page 10 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUIL B. WING	DING	ONSTRUCTION 00	(X3) DATE : COMPL 04/13 /	ETED	
	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE N MICHIGAN RD /ILLE, IN 46077		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
R0091	Noncompliance (h) The facility sha written policy in resident care and attained, to incluid (1) The range of (2) Residents' rig (3) Personnel and (4) Facility operative policies shall residents upon residents and proceed reviewed for abut (#H) Findings include The record of Resident and resi	and Management - nall establish and implement hanual to ensure that d facility objectives are de the following: services offered. hts. ministration. tions. I be made available to equest. ation, interview and e facility failed to ensure redures for abuse nplemented. An se was not reported to the r 1 of 5 residents se in the sample of 5. sident #H was reviewed 00 a.m. led, but were not limited foint disease of the left repertension, depression,	R00	91	1. On 4/12/12 the Administrat interviewed 6 staff members involved in the incident on Mar 7, 2012. During the interview Employee #1 gave an account suspected abuse. Employee #3 as well as the accused Employ #2, were both suspended pendinvestigation. At the conclusion of the investigation, Employee was counseled on proper reporting procedure. It was marked to Employee #1 that timeliness of reporting abuse in the first place. Employee #1 this signed an abuse policy acknowledgement form. 2. The Administrator interviewed other employees and residents that were in the community on the evening of March 7, 2012. No other incidents were reported a suspicious. 3. On 4/20/12 the Administrator conducted an abuse in-service for all staff members. The in-service attendance sheet is submitted appendix A. This in-service	rch t of #1, yee ding on #1 ade as hen The er	04/20/2012

State Form Event ID: TR0X11 Facility ID: 012263 If continuation sheet Page 11 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
			B. WIN			04/13/	2012
			1		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	t.			N MICHIGAN RD		
	AT TUDOR GARD	ENS LLC			/ILLE, IN 46077		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	toileting and per	sonal hygiene. The			included clear definitions of ou		
	service plan indicated, "Requires				abuse policy, appendix B. Spe		
	assistance with b	pathing. Special			focus was put on the courage it may take for friends and	llial	
	requirements for	bathing - repeated			co-workers to report other frier	nds	
	_	o bathe. Difficult to			and co-workers if abuse is	-	
	1	ase manager to give			suspected. All employees took		
		n D/T [due to] resident			post test, appendix C, includin	g	
	` ′				true/false questions and a	_	
	gets aggressive v				specific question regarding wh		
	approached for bathsJudgement and				they would report abuse to. The answers to the test were	C	
	memory are generally good. Needs				reviewed during the in-service	. It	
	monitoring and guidance"				is clear to all employees that		
					suspected abuse is to be		
	The most current	t Fall Risk Evaluation			immediately reported to the		
	dated 2/24/12, in	dicated Resident #H was			Administrator. The		
	a medium fall ris	sk. The evaluation			Administrator's name and pho	ne	
	indicated the resi	ident was disoriented x 1,			number was placed in highly visible areas around the		
		he past 3 months, had			community for employees to		
		s while standing/walking			report abuse appropriately. 4		
	•	dications in the categories			The Administrator will conduct		
		ld increase the risk of			sample interviews of 2 staff		
		id increase the risk of			members monthly specifically		
	falls.				asking for any unreported or questionable incidents. All		
					directors will reassure employe	ees	
		ted 3/7/12 at 7:15 p.m.			of their open door for		
	indicated, "Res [resident] refused to put			communication.		
	clothes on after s	shower. Staff exited Res					
	room to allow Ro	es time to					
	de-escalateRes	came out into hallway					
		empted to redirect Res					
		began screaming and					
		Staff left Res alone to					
	_						
	de-escalate. Res began following staff into other Res rooms swearing and						
		•					
	_	nily [and] management					
	[[and] MD [Medi	cal Doctor] notified."					

State Form Event ID: TR0X11 Facility ID: 012263 If continuation sheet Page 12 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CON	ISTRUCTION	(X3) DATE S		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED		
		B. WING			04/13/	2012	
		I	STRE	EET AE	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				I MICHIGAN RD		
HEARTH	AT TUDOR GARD	ENS LLC			LLE, IN 46077		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	ζ .	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		DATE
TAG	X (EACH DEFICIENCY MUST BE PERCEDED BY FULL		TAG		DEFICIENCY		DATE
		ical system] to transport					
		gency room] for eval					
		s would not allow this					
	writer to assess s	kin at this time."					
		ted 3/7/12 at 8:20 p.m. arrived to transport					
	The record lacke injury to Residen	d documentation of any at #H on 3/7/12.					
	During an intervi						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	00	COMI	E SURVEY PLETED 3/2012	
NAME OF PROVIDER OR SUPPLIER			11755	ADDRESS, CITY, STATE, ZIP C	CODE	
HEARTH AT TUDOR GARDENS LLC			ZIONS	/ILLE, IN 46077		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	a.m., LPN [Licer indicated a CNA Assistant] witner down a resident. incident involved CNA who witner was CNA #2. During an interved p.m., CNA #5 in pulled her braid combative. She assisting her in good shower when the CNA #5 indicated [name of CNA # #2's ear, from whearring, started by the companion of the com	nsed Practical Nurse] #6 [Certified Nursing seed a staff member push She indicated the direct Resident #H and the seed the alleged abuse iew on 4/12/12 at 12:28 dicated Resident #H had out when the resident was indicated CNA #2 was giving Resident #H a resident was "upset." ied the resident "went for 2]" and indicated CNA mat she thought was an		CROSS-REFERENCED TO THE A		
	the CNAs dried resident's clothes CNA #2 indicate	the floor, laid out the s and left the resident. Ed the resident came out the cout clothes on and				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LDING	NSTRUCTION 00	(X3) DATE : COMPL 04/13/	ETED	
NAME OF PROVIDER OR SUPPLIER			J. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
HEARTH AT TUDOR GARDENS LLC				ZIONSV	/ILLE, IN 46077		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	chased the CNAs CNA #2 indicate re-direct the resic Qualified Medica came out to help be re-directed an CNA #2 indicate off 2 and 2 to con care to the other care unit while Qualified whi were giving care the resident's roof and pulled out a CNA's hair and be causing it to blee LPN #3 and QM back toward her CNA #2 indicate walk behind the resident into her resident to fall an the room. CNA LPN #3] turned and then left the indicated QMA # call 911. CNA # only witness. Cl watched at the do resident get up. went to get anoth assist the resident	cd they attempted to dent. CNA #2 indicated ation Aide [QMA] #4 The resident could not d LPN #3 came to assist. Ed the four CNAs paired intinue giving resident residents in the memory QMA #4 and LPN #3 If for Resident #H. CNA to a different resident in the memory on, Resident #H came in braid extension from that int CNA #2 in the ear ed. CNA #2 indicated A #4 took Resident #H					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPL: - 04/13/	ETED	
NAME OF I	PROVIDER OR SUPPLIEF	<u> </u>		ADDRESS, CITY, STATE, ZIP CO	ODE	
HEARTH AT TUDOR GARDENS LLC				N MICHIGAN RD VILLE, IN 46077		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	indicated when so CNA, Resident # The CNA indicated the amount transported Resident # report the incident the director of the	the returned with another the was "calm and sweet." ted Resident #H could that happened. CNA #2 bulance came and dent #H out of the 2 indicated she did not not to the administrator, the memory care unit, or arising because she was and was afraid of inistration. CNA #2 is aware of facility policy. The was supposed to report the indicated she learned grand reporting abuse in the was abuse allegation with a distribution of the was abuse allegation was allegation was allegation was abuse allegation and the was abuse allegation of 3/7/12. The Administrator aware was abuse allegation of 3/7/12. The Administrator aware was abuse allegation of 3/7/12.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE COMPL 04/13 /	LETED			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 11755 N MICHIGAN RD ZIONSVILLE, IN 46077					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE		
TAU	immediately remand begin an invade Administrator in that at least one report an allegate During an observed to be in away from the manufacture of	estigation. The dicated he was not aware employee was afraid to ion of abuse. vation on 4/13/12 at dent #H's room was a the middle of a hallway main activity room and the memory care unit is mare.	IAU			DATE		
	sign-in sheet rela	rovided an employee ated to the abuse rvice dated 3/16/12 at						
	dated 9/27/11 an was the most cur indicated, "Rej confirmed abuse presented immed Administrator. (rovided the Abuse Policy d indicated this policy rent. The policy corts of suspected or or neglect must be diately to the Confirmed abuse/neglect to the State Department						
	a.m., the Admini	iew on 4/10/12 at 11:00 istrator indicated that all use or neglect must be						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE COMPI 04/13		
NAME OF PROVIDER OR SUPPLIER HEARTH AT TUDOR GARDENS LLC			11755 1	ADDRESS, CITY, STATE, ZIP COD N MICHIGAN RD VILLE, IN 46077	DE .	
HEARTH (X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) reported to the state agency. On 4/11/12 at 3:05 p.m., the Administrator provided the most recent Abuse Prevention Addendum with a review date of 4/11/12. The Abuse Prevention Addendum indicated, "Prevention of abuse training will be provided upon hiring and annual thereafterEmployees' main		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPIDEFICIENCY)	LD BE	(X5) COMPLETION DATE
	responsibility is safety if there is harm to a resider all situations that abuse or neglect and all sources. employees or other abuse or neglect of suspected or conneglect must be the Administrator.	to proved (sic) immediate a potential of abuse or atEmployees will report a may be considered to a resident from any Retaliation to residents, ares who report suspected is not permitted. Reports onfirmed abuse or presented immediately to				

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